State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-3900/P1
DAK&PJK:bg:pg

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and *to create* 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers, insurers, and governmental self-insured plans; requiring acceptance by a health care provider of a payment amount in certain circumstances; and requiring the exercise of rule-making authority.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided on a subsequent version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)

and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to (15), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 5. 146.903 of the statutes is created to read:

146.903 Disclosures required of health care providers. (1) In this section:

(a) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) "Average charged rate" means the average amount that is currently charged by a health care provider to a patient for a health care service, diagnostic test, or procedure.

(c) "Average paid rate" means the average amount that a health care provider currently accepts as payment in full for a health care service, diagnostic test, or procedure, after any discount applicable to certain patients is applied.

(d) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

(e) "Course of treatment" means, as part of a health care service, the management and care, including related therapy and rehabilitation, of a patient over time for the purpose of combating disease or disorder or temporarily or permanently relieving symptoms.

(f) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(g) "Health care provider" has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center.

(h) "Health care service, diagnostic test, or procedure" includes physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy.

(i) "Insured" means covered under a health care plan offered by an insurer or under a self-insured health plan.

(j) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that provides coverage, excluding public coverage, of health care expenses under health care plans covering individuals or groups in this state. The term includes a health maintenance

organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01 (3).

(k) "Medical Assistance" means aid provided under subch. IV of ch. 49, other than aid under s. 49.471.

(L) "Medicare" means coverage under Part A or Part B of Title XVIII of the federal social security act, 42 USC 1395 to 1395zz.

(m) "Mental therapy" includes services and treatment for mental illness, developmental disability, alcohol and other drug abuse, and drug dependence.

(n) "Minimum cost" means $500 or any higher amount that is specified by the department by rule.

(p) "Patient's agent" means the parent, guardian, or legal custodian of a minor patient; the spouse of a patient; an agent of a patient under a valid power of attorney for health care; a guardian of the person, as defined in s. 54.01 (12) of a patient; or any individual who is authorized by the patient to act as his or her agent.

(q) "Public coverage" means coverage for health care expenses that is funded in whole or in part under any state-assisted or federally assisted program other than BadgerCare Plus under s. 49.471, including Medical Assistance and Medicare, for which the average reimbursement rate for a health care service, diagnostic test, or procedure is lower than an insurer's or self-insured health plan's average paid rate for the identical service, test, or procedure.

(r) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) (a) If a patient is not insured or does not have public coverage at the time he or she first receives a particular health care service, diagnostic test, or procedure

or the first treatment or visit of a course of treatment and, within 90 days after receipt of the service, test, procedure, or treatment, obtains from an insurer or self-insured health plan coverage that is under a contract for not less than one year, the health care provider shall accept, as payment for the service, test, or procedure provided to the patient, no more than the insurer's or plan's payment amount for that service, test, or procedure, except that the patient may be liable to the health care provider for any out-of-pocket costs, finance charges, and collection costs incurred that would not have been covered under the patient's coverage.

(b) The health care provider of a patient who is not insured or who does not have public coverage at the time that a health care service, diagnostic test, or procedure is provided or after the first treatment or visit of a course of treatment shall inform the patient of the requirement under par. (a) and of the provider's reimbursement requirement for a recipient of Medical Assistance under s. 49.49 (3m) (a) 2.

(c) The insurer or self-insured health plan who provides coverage specified under par. (a) shall provide to the patient a dollar estimate of the insurer's or plan's applicable payment amount for the health care service, diagnostic test, or procedure received by the patient.

(3) (a) If a health care provider recommends, refers for service, or prescribes a health care service, including any applicable course of treatment, diagnostic test, or procedure for which the charge exceeds the minimum cost, and if a patient or his or her agent requests an estimate of the charge, the health care provider shall provide one of the following:

1. For a patient who is insured, a written description of the health care service, diagnostic test, or procedure that includes the appropriate medical code or codes that

would enable the patient or patient's agent to obtain applicable coverage payment information from the patient's insurer or self-insured health plan.

2. An estimate of the charge.

(b) Except as provided in par. (c) 2., if a patient or the patient's agent requests from a health care provider an estimate of the charge for a health care service, diagnostic test, or procedure which will, or for which the course of treatment will, exceed the minimum cost, the health care provider shall provide the following estimate of the charge, as applicable, at the time of scheduling of the service, diagnostic test, procedure, or course of treatment or within 7 days of the request, whichever is later:

1. For an inpatient surgical procedure and course of treatment, the estimate of the charge shall include all of the following:

a. The reasonably anticipated services of health care providers who will likely provide health care services, during and after the surgical procedure and during any related course of treatment.

b. The reasonably anticipated total charge for hospitalization, daily charge for hospitalization, and number of days of hospital stay.

2. For an outpatient surgical procedure and course of treatment, the estimate of the charge shall include the reasonably anticipated total charge.

3. For an inpatient or outpatient surgical procedure and course of treatment, objective quality data related to the health outcome of the proposed procedure and course of treatment, if the health care provider has made public the data.

4. For a nonsurgical hospital procedure and course of treatment, the estimate of the charge shall include the reasonably anticipated services of health care

providers who will likely provide health care services during and after the procedure and any related course of treatment.

5. For physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy, the estimate of the charge shall include all of the following:

a. A proposed treatment plan that describes the number and frequency of visits of a course of treatment and the anticipated charges for the course of treatment. If the course of treatment is anticipated to exceed 6 months and if the patient or the patient's agent so requests, the health care provider shall provide an estimate of the charge and course of treatment plan for each anticipated 6 month period.

b. Objective quality data related to the health outcome of the proposed course of treatment, if the health care provider has made public the data.

(c) 1. All of the following applies to an estimate of charge provided under this subsection:

a. The estimate of the charge shall represent a health care provider's good-faith effort to provide accurate information to the patient or the patient's agent.

b. The estimate of the charge shall inform the patient of his or her responsibilities in complying with any medical requirements for the patient that are associated with any health care service, diagnostic test, or procedure proposed; and the potential of cost variances that are due to factors that cannot reasonably be anticipated.

c. The estimate of the charge shall indicate how the health status of the patient may contribute to any charge variances that may reasonably be anticipated.

d. The estimate of the charge shall be made available to the patient or the patient's agent.

e. The estimate of the charge shall include any discounts or financial incentives the health care provider offers for obtaining a health care service, diagnostic test, or procedure that is provided by the health care provider.

f. The estimate of the charge may, if requested by the patient or the patient's agent, be issued electronically.

2. In lieu of the requirements under par. (b), a health care provider may provide to the patient or the patient's agent an estimate of the charge that is a single fixed-price estimate of the total cost of the health care service, diagnostic test, or procedure, the amount of which the health care provider shall accept as payment in full.

3. All of the following applies to an estimate of the charge provided under this subsection for a patient who is insured:

a. The health care provider may provide the average paid rate paid by insurers and self-insured health plans, the average charged rate billed to insurers and plans, or a rate that is lower than the average charged rate billed to private insurers, if each rate that is provided is clearly labeled in the estimate of the charge.

b. The estimate of the charge shall contain language that encourages the patient to review the estimate carefully and to contact his or her insurer or self-insured health plan for specific coverage information.

4. All of the following applies to an estimate of the charge provided under this subsection for a patient who is not insured:

a. If the health care provider determines, on the basis of preliminary information, that the patient is eligible for Medical Assistance or is eligible for but not enrolled in Medicare and the health care provider accepts ~~Medical Assistance~~ recipients or ~~Medicare~~ beneficiaries, the estimate of the charge shall include the paid

rate received by the health care provider for a patient who is a ~~Medical Assistance~~ recipient or a ~~Medicare~~ beneficiary, whichever is applicable, or a rate lower than that rate; shall contain language that encourages the patient to review the estimate carefully and to apply for Medical Assistance or enroll in Medicare, as applicable; and shall inform the patient or the patient's agent of the requirements of s. 49.49 (3m) (a) 2.

b. If the health care provider cannot determine if the patient is eligible for Medical Assistance or Medicare, the estimate of the charge shall include the average paid rate paid by insurers and self-insured health plans or a rate lower than that rate; shall contain language that encourages the patient to review the estimate carefully and to obtain insurance coverage; and shall inform the patient or the patient's agent of the terms and conditions under which the average paid rate or another paid rate may be applicable.

(4) (a) In this subsection, "consumer price index" means the average of the consumer price index over each 12-month period, all items, U. S. city average, as determined by the bureau of labor statistics of the U. S. department of labor.

(b) The department shall, by rule, biennially adjust the dollar amount that is specified for minimum cost under sub. (1) (~~b~~) by calculating any percentage difference between the consumer price index for the 12-month period ending on December 31 of the most recent odd-numbered year and the consumer price index for the 12-month period ending on December 31 of the next most recent odd-numbered year and applying that percentage difference, if any, to the most-recently specified dollar amount for minimum cost under this subsection or sub. (1) (~~b~~). If a percentage difference exists, the department shall by rule prescribe a revised dollar amount that reflects the percentage difference, which amount shall

be in effect until a subsequent rule is promulgated under this subsection. Notwithstanding s. 227.24 (1) (a), (2) (b), or (3), the department is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 6. 185.981 (4t) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.71 of the statutes is created to read:

609.71 Disclosure of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.798.

SECTION 9. 632.798 of the statutes is created to read:

632.798 Disclosure of information. (1) DEFINITIONS. In this section:

(a) "Cost-sharing requirements" means copayments, deductibles, coinsurance percentages, and any other cost-sharing mechanisms that apply under a health care plan or self-insured health plan.

(b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(c) "Insured" means a person covered under a health care plan offered by an insurer or an enrollee under a self-insured health plan.

(d) "Insured's agent" means a parent, guardian, or legal custodian of an insured who is a minor child; the spouse of an insured; an agent of an insured under a valid power of attorney for health care; a guardian of the person, as defined in s. 54.01 (12), of an insured; or anyone authorized by an insured to act as his or her agent.

(e) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that provides coverage, excluding public coverage, of health care expenses under health care plans covering individuals or groups in this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01 (3).

(f) "Participating" has the meaning given in s. 609.01 (3m).

(g) "Provider" means a health care provider, as defined in s. 146.81 (1).

(h) "Public coverage" means coverage for health care expenses that is funded in whole or in part under any state-assisted or federally assisted program, including Medical Assistance under subch. IV of ch. 49 and Medicare under 42 USC 1395 to

1395(2), the average paid rate of which is lower than an insurer's average paid rate for the same medical service.

(i) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) INFORMATION REQUIRED. An insurer or self-insured health plan shall provide any of the following information if requested by an insured or an insured's agent:

(a) A description of the coverage, including benefits and cost-sharing requirements, under the insured's health care plan or self-insured health plan.

(b) A description of pre-certification or other requirements, if any, that an insured must complete before any care is approved by the insurer or self-insured health plan.

(c) A summary of the insured's coverage with respect to a specific medical service or course of treatment, including all of the following information:

1. The estimated total and type of out-of-pocket costs that the insured may incur, including deductibles, copayments, coinsurance, and items and other charges that are not covered by the insurer or self-insured health plan.

2. An estimate of the amount or rate that the insurer or self-insured health plan will pay to a provider for the specific medical procedure or course of treatment. The estimate under this subdivision may provide the payment amount or rate in such a way that protects the insurer's proprietary pricing, but shall be a reasonably close estimate of the actual amount or rate that will be paid.

3. Any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from a provider that is not a participating provider. If the insured provides to the insurer or self-insured health plan the applicable medical code or codes for the service or course of treatment provided or proposed to be provided by a provider or providers that are not participating, the

insurer or self-insured health plan shall inform the insured if the cost of the service or course of treatment exceeds the allowable charge under the insurer's or self-insured health plan's guidelines for payment for the service or course of treatment under the insured's health care plan or self-insured health plan.

4. Any discounts or financial incentives that the insurer or self-insured health plan is willing to offer the insured, including incentives for the insured to obtain care or a course of treatment from a different provider.

5. That the information in the summary represents the insurer's or self-insured health plan's best estimate of the amounts provided.

(3) GENERAL PROVISIONS. (a) The information under sub. (2) may be provided to the insured electronically or verbally, whichever is preferred by the insured.

(b) The insurer or self-insured health plan shall make a good faith effort to provide accurate information to the insured under sub. (2).

(c) An insurer or self-insured health plan may satisfy the requirement to provide any of the information under sub. (2) by providing a method by which an insured or insured's agent may obtain the information on his or her own, such as on a Web site.

SECTION 10. Initial applicability.

(1) DISCLOSURE OF INFORMATION. If a health care plan or a governmental self-insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a health care provider and a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with this act, this act first applies to that disability insurance policy, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

(1) This act takes effect on the first day of the 19th month beginning after publication. ✓

(END) ✓

INSERT A

Under current law, as affected by 2007 Wisconsin Act 20 (the biennial budget act), if an applicant for Medical Assistance (MA) is determined to be eligible for MA retroactively (for three months) and a provider bills the applicant directly for services and benefits rendered during the retroactive period, the provider must submit MA claims for those services and benefits that are covered under MA. Upon receiving MA payment under the claims, the provider must reimburse the MA recipient, or other person who made the prior payment on behalf of the recipient, for services provided to the recipient during the retroactive eligibility period, by the amount of the prior payment made.

This bill restricts payment that a health care provider, as defined in the bill, may accept from certain patients who are uninsured or who do not have public coverage (as defined in the bill). If the patient, within 90 days after receiving a health care service, diagnostic test, procedure or the first treatment or visit of a course of treatment as part of a health care service, obtains coverage from an insurer or a self-insured health plan under a contract for not less than one year, the health care provider must accept, as payment from the patient for the service, test, or procedure no more than the insurer's or plan's payment amount for that service, test, or procedure. However, the patient may be liable to the health care provider for out-of-pocket costs, finance charges, and collection costs incurred that would not have been covered under the patient's coverage. The insurer or self-insured health plan that provides coverage must provide to the patient a dollar estimate of the applicable payment amount for the service, test, or procedure the patient received. Also, under the bill, a health care provider must provide to a patient who is uninsured or does not have public coverage, at the time the health care service, test, or procedure is provided or after the first treatment or visit of a course of treatment, information about this restriction on payment and information about the restriction on acceptance of patient payment for MA applicants who receive retroactive eligibility.

Under the bill, if a health care provider recommends, refers for service, or prescribes a health care service (including any applicable course of treatment), diagnostic test, or procedure for which the charge exceeds $500 or any higher amount that the Department of Health and Family Services (DHFS) promulgates by rule (the minimum cost), and if the patient or his or her agent requests an estimate of the charge, the health care provider must provide an estimate of the charge or, for a patient who is insured, a written description of the service, test, or procedure that includes the appropriate medical code or codes that would enable the patient or his or her agent to obtain applicable coverage payment information from his or her insurer or self-insured health plan. The estimate of the charge must be provided at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment, or within 7 days of the request, whichever is later. The bill specifies numerous requirements for the estimate of charge, except that, in lieu of several of the requirements, a health care provider may provide to the patient or his or her

seven

agent an estimate of charge that is a single fixed-price estimate of the total cost of the health care service, diagnostic test, or procedure, the amount of which the health care provider must accept as payment in full.

The bill requires DHFS, by rule, biennially to adjust the dollar amount that is specified for minimum cost and specifies a procedure, using the consumer price index, by which the adjusted dollar amount must be calculated. DHFS may promulgate the amount as an emergency rule without providing a finding of emergency or complying with certain other standards for promulgating emergency rules.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

Insert A-PJK

end of inserts

2007-2008 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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The bill requires a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides health care coverage under a health care plan, including a defined network plan or a sickness care plan operated by a cooperative association, to provide to an insured under the health care plan or an enrollee under the self-insured health plan, any of the following if requested by the insured or enrollee: 1) a description of the coverage, including benefits and cost-sharing requirements, under the health care plan or self-insured health plan; 2) a description of any pre-certification or other requirements that an insured or enrollee must complete before any care is approved by the insurer or self-insured health plan; and 3) a summary of the insured's or enrollee's coverage with respect to a specific medical service or course of treatment. The summary of coverage must include an estimate of the total out-of-pocket costs that the insured or enrollee may incur, an estimate of the amount that the insurer or self-insured health plan will pay to the provider, any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from a nonparticipating or out-of-network provider, any discounts that the insurer or self-insured health plan is willing to offer the insured or enrollee if the service or course of treatment is received from a different provider, and that the information in the summary represents the insurer's or self-insured health plan's best estimate. The bill requires an insurer or self-insured health plan to make a good faith effort to provide accurate information and allows an insurer or self-insured health plan to provide a method, such as a website, by which an insured or enrollee may obtain the information on his or her own.

(END OF INSERT A-PJK)

Kennedy, Debora

From: Vukmir, Leah
Sent: Monday, February 04, 2008 8:48 AM
To: Kennedy, Debora; Kahler, Pam
Cc: Cady, Dean
Subject: LRB 3900/1

Deborah & Pam,

After discussing the provisions in the bill with providers and insurers, we need to make several changes to LRB 3900/1.

1. On page 7, lines 17 to 27 - Remove this provision. Insurers need both the codes and a cost in order to develop their estimate.

2. The language from (3)(a) 1 is good but must be a requirement for all estimates, so please add that requirement on page 9, (3)(c) 1.

3. In addition to the codes, insurers need to know the identity of the providers, including the location of any provider's facility.- add to (3)(c) 1.

4. On page 7, under (3)(a) 2(b), providers want us to make it clear that every provider is required to make this information available. For example, a doctor who will be performing a surgery may not be able to "require" the other providers to cooperate in offering this information, unless the law says they must.

To make this more clear, we would like to add language at page 7, line 23. We would like it to say:

"requested under par. (a), the health care provider, or group of providers jointly, if applicable, shall provide the following,"

If you would like to substitute language that expresses this same meaning, that would be fine.

5. Please add on page 10, as 3(c), "A provider or group of providers may, in lieu of issuing an estimate of charge to the patient, arrange to provide the patient's insurer the estimate of charge for presentation to the patient under 632.798.

6. At page 10, lines 12-21 should be replaced with the following:
If the health care provider determines, on the basis of preliminary information, that the patient is eligible for Medical Assistance or is eligible for but not enrolled in Medicare and the health care provider accepts recipients of Medical Assistance or beneficiaries of Medicare, the estimate of the charge shall include the average paid rate paid by insurers and self–insured health plans or a rate lower than that rate; shall contain language that encourages the patient to review the estimate carefully and to apply for Medical Assistance or enroll in Medicare, as applicable; and shall inform the patient or the patient's agent of the requirements of s. 49.49 (3m) (a) 2.

7. On page 13 at line 19 – The "Information Required" from the insurer is directly related to the estimate of charges from the provider. The insurer's summary is generated from the information given by the provider's estimate. The current bill does not make this distinction clear.

8. On page 14 at line 6 – it should include the amount paid to a provider (or providers)

9. On page 14 at line 23 & 24 – the insurer should also indicate that the information is based on the estimate of charges issued by the provider or group of providers.

10. Providers and insurers are concerned that these estimates may be considered contracts or guarantees. They want the bill to expressly address this issue.

Please feel free to adjust this recommended text as you see fit.

For insurers,
The estimate may include a statement or that indicates that the information provided represents an estimate and should not be considered a guarantee of payment.

For providers:
The estimate may include a statement that indicates that the information provided represents an estimate and should not be considered a guarantee of total charges.

11. On page 15 – delete lines 5 – 8.

12. Replace that paragraph (page 15, lines 5-8) with a provision that refers to the change from item 5 (above).

Citing the provision under 146.903, if an insurer has arranged with a provider or group of providers to present an estimate of charge, the insurer shall include the information required under 146.903 in addition to the information required under sub (2).

Please let us know if you have any quetions.

Thanks,

Leah

TODAY

State of Wisconsin
2007 - 2008 LEGISLATURE

D-NOTE

LRB-3900/1
DAK&PJK:bk:pg

2007 BILL

Inserts

SAV

regen. cat

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers, insurers, and governmental self-insured plans; requiring acceptance by a health care provider of a payment amount in certain circumstances; and requiring the exercise of rule-making authority.

Analysis by the Legislative Reference Bureau

Under current law, as affected by 2007 Wisconsin Act 20 (the biennial budget act), if an applicant for Medical Assistance (MA) is determined to be eligible for MA retroactively (for three months) and a provider bills the applicant directly for services and benefits rendered during the retroactive period, the provider must submit MA claims for those services and benefits that are covered under MA. Upon receiving MA payment under the claims, the provider must reimburse the MA recipient, or other person who made the prior payment on behalf of the recipient, for services provided to the recipient during the retroactive eligibility period, by the amount of the prior payment made.

This bill restricts payment that a health care provider, as defined in the bill, may accept from certain patients who are uninsured or who do not have public coverage (as defined in the bill). If the patient, within 90 days after receiving a health care service, diagnostic test, procedure or the first treatment or visit of a course of

treatment as part of a health care service, obtains coverage from an insurer or a self-insured health plan under a contract for not less than one year, the health care provider must accept, as payment from the patient for the service, test, or procedure no more than the insurer's or plan's payment amount for that service, test, or procedure. However, the patient may be liable to the health care provider for out-of-pocket costs, finance charges, and collection costs incurred that would not have been covered under the patient's coverage. The insurer or self-insured health plan that provides coverage must provide to the patient a dollar estimate of the applicable payment amount for the service, test, or procedure the patient received. Also, under the bill, a health care provider must provide to a patient who is uninsured or does not have public coverage, at the time the health care service, test, or procedure is provided or after the first treatment or visit of a course of treatment, information about this restriction on payment and information about the restriction on acceptance of patient payment for MA applicants who receive retroactive eligibility.

INSERT A

Under the bill, if a health care provider recommends, refers for service, or prescribes a health care service (including any applicable course of treatment), diagnostic test, or procedure for which the charge exceeds $500 or any higher amount that the Department of Health and Family Services (DHFS) promulgates by rule (the minimum cost), and if the patient or his or her agent requests an estimate of the charge, the health care provider must provide an estimate of the charge or, for a patient who is insured, a written description of the service, test, or procedure that includes the appropriate medical code or codes that would enable the patient or his or her agent to obtain applicable coverage payment information from his or her insurer or self-insured health plan. The estimate of the charge must be provided at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment, or within seven days of the request, whichever is later. The bill specifies numerous requirements for the estimate of charge, except that, in lieu of several of the requirements, a health care provider may provide to the patient or his or her agent an estimate of charge that is a single fixed price estimate of the total cost of the health care service, diagnostic test, or procedure, the amount of which the health care provider must accept as payment in full.

The bill requires DHFS, by rule, biennially to adjust the dollar amount that is specified for minimum cost and specifies a procedure, using the consumer price index, by which the adjusted dollar amount must be calculated. DHFS may promulgate the amount as an emergency rule without providing a finding of emergency or complying with certain other standards for promulgating emergency rules.

The bill requires a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides health care coverage under a health care plan, including a defined network plan or a sickness care plan operated by a cooperative association, to provide to an insured under the health care plan or an enrollee under the self-insured health plan, any of the following if requested by the insured or enrollee: 1) a description of the coverage, including benefits and cost-sharing requirements, under the health care plan or self-insured health plan;

2) a description of any pre-certification or other requirements that an insured or enrollee must complete before any care is approved by the insurer or self-insured health plan; and 3) a summary of the insured's or enrollee's coverage with respect to a specific medical service or course of treatment. The summary of coverage must include an estimate of the total out-of-pocket costs that the insured or enrollee may incur, an estimate of the amount that the insurer or self-insured health plan will pay to the provider, any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from a nonparticipating or out-of-network provider, and any discounts that the insurer or self-insured health plan is willing to offer the insured or enrollee if the service or course of treatment is received from a different provider. The bill requires an insurer or self-insured health plan to make a good faith effort to provide accurate information and allows an insurer or self-insured health plan to provide a method, such as a Web site, by which an insured or enrollee may obtain the information on his or her own.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to (15), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 5. 146.903 of the statutes is created to read:

146.903 Disclosures required of health care providers. (1) In this section:

(a) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) "Average charged rate" means the average amount that is currently charged by a health care provider to a patient for a health care service, diagnostic test, or procedure.

(c) "Average paid rate" means the average amount that a health care provider currently accepts as payment in full for a health care service, diagnostic test, or procedure, after any discount applicable to certain patients is applied.

(d) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

(e) "Course of treatment" means, as part of a health care service, the management and care, including related therapy and rehabilitation, of a patient over time for the purpose of combating disease or disorder or temporarily or permanently relieving symptoms.

(f) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(g) "Health care provider" has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center.

(h) "Health care service, diagnostic test, or procedure" includes physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy.

(i) "Insured" means covered under a health care plan offered by an insurer or under a self-insured health plan.

(j) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that provides coverage, excluding public coverage, of health care expenses under health care plans covering individuals or groups in this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01 (3).

(k) "Medical Assistance" means aid provided under subch. IV of ch. 49, other than aid under s. 49.471.

(L) "Medicare" means coverage under Part A or Part B of Title XVIII of the federal social security act, 42 USC 1395 to 1395hhh.

(m) "Mental therapy" includes services and treatment for mental illness, developmental disability, alcohol and other drug abuse, and drug dependence.

(n) "Minimum cost" means $500 or any higher amount that is specified by the department by rule.

(p) "Patient's agent" means the parent, guardian, or legal custodian of a minor patient; the spouse of a patient; an agent of a patient under a valid power of attorney for health care; a guardian of the person, as defined in s. 54.01 (12) of a patient; or any individual who is authorized by the patient to act as his or her agent.

(q) "Public coverage" means coverage for health care expenses that is funded in whole or in part under any state-assisted or federally assisted program other than BadgerCare Plus under s. 49.471, including Medical Assistance and Medicare, for which the average reimbursement rate for a health care service, diagnostic test, or procedure is lower than an insurer's or self-insured health plan's average paid rate for the identical service, test, or procedure.

(r) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) (a) If a patient is not insured or does not have public coverage at the time he or she first receives a particular health care service, diagnostic test, or procedure or the first treatment or visit of a course of treatment and, within 90 days after receipt of the service, test, procedure, or treatment, obtains from an insurer or a self-insured health plan coverage that is under a contract for not less than one year, the health care provider shall accept, as payment from the patient for the service, test, or procedure provided to the patient, no more than the insurer's or plan's payment amount for that service, test, or procedure, except that the patient may be liable to the health care provider for any out-of-pocket costs, finance charges, and

collection costs incurred that would not have been covered under the patient's coverage.

(b) The health care provider of a patient who is not insured or who does not have public coverage at the time that a health care service, diagnostic test, or procedure is provided or after the first treatment or visit of a course of treatment shall inform the patient of the requirement under par. (a) and of the provider's reimbursement requirement for a recipient of Medical Assistance under s. 49.49 (3m) (a) 2.

(c) The insurer or self-insured health plan that provides coverage specified under par. (a) shall provide to the patient a dollar estimate of the insurer's or plan's applicable payment amount for the health care service, diagnostic test, or procedure received by the patient, as specified under par. (a).

(3) (a) If a health care provider recommends, refers for service, or prescribes a health care service, including any applicable course of treatment, or diagnostic test or procedure for which the charge exceeds the minimum cost, and if a patient or the patient's agent requests an estimate of the charge, the health care provider shall provide one of the following:

1. For a patient who is insured, a written description of the health care service, diagnostic test, or procedure that includes the appropriate medical code or codes that will enable the patient or patient's agent to obtain applicable coverage payment information from the patient's insurer or self-insured health plan.

2. An estimate of the charge.

(b) Except as provided in par. (c) 2., for an estimate of the charge that is requested under par. (a), the health care provider shall provide the following, as applicable, at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment or within 7 days of the request, whichever is later:

e. The estimate of the charge shall include

x2 or group of health care providers jointly if applicable

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1. For an inpatient surgical procedure and course of treatment, an estimate of the charge that shall include all of the following:

a. The reasonably anticipated services of health care providers who will likely provide health care services, during and after the surgical procedure and during any related course of treatment.

b. The reasonably anticipated total charge for hospitalization, daily charge for hospitalization, and number of days of hospital stay.

2. For an outpatient surgical procedure and course of treatment, an estimate of the charge that shall include the reasonably anticipated total charge.

3. For an inpatient or outpatient surgical procedure and course of treatment, objective quality data that is related to the health outcome of the proposed procedure and course of treatment, if the health care provider has made public the data.

4. For a nonsurgical hospital procedure and course of treatment, an estimate of the charge that shall include the reasonably anticipated services of health care providers who will likely provide health care services during and after the procedure and any related course of treatment.

5. For physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy, an estimate of the charge that shall include all of the following:

a. A proposed treatment plan that describes the number and frequency of visits of a course of treatment and the anticipated charges for the course of treatment. If the course of treatment is anticipated to exceed 6 months and if the patient or the patient's agent so requests, the health care provider shall provide an estimate of the charge and course of treatment plan for each anticipated 6 month period.

b. Objective quality data that is related to the health outcome of the proposed course of treatment, if the health care provider has made public the data.

(c) 1. All of the following applies to an estimate of the charge provided under this subsection:

a. The estimate of the charge shall represent ~~a health care provider's~~ the good-faith effort to provide accurate information to the patient or the patient's agent.

b. The estimate of the charge shall inform the patient of his or her responsibilities in complying with any medical requirements for the patient that are associated with any health care service, diagnostic test, or procedure proposed; and the potential of cost variances that are due to factors that cannot reasonably be anticipated.

c. The estimate of the charge shall indicate how the health status of the patient may contribute to any charge variances that may reasonably be anticipated.

d. The estimate of the charge shall be made available to the patient or the patient's agent.

e. The estimate of the charge shall include any discounts or financial incentives the health care provider offers for obtaining a health care service, diagnostic test, or procedure that is provided by the health care provider.

f. The estimate of the charge may, if requested by the patient or the patient's agent, be issued electronically.

2. In lieu of the requirements under par. (b), a health care provider may provide to the patient or the patient's agent an estimate of the charge that is a single fixed-price estimate of the total cost of the health care service, diagnostic test, or procedure, the amount of which the health care provider shall accept as payment in full.

3. All of the following applies to an estimate of the charge provided under this subsection for a patient who is insured:

a. The health care provider may provide the average paid rate paid by insurers and self-insured health plans, the average charged rate billed to insurers and plans, or a rate that is lower than the average charged rate billed to private insurers, if each rate that is provided is clearly labeled in the estimate of the charge.

b. The estimate of the charge shall contain language that encourages the patient to review the estimate carefully and to contact his or her insurer or self-insured health plan for specific coverage information.

4. All of the following applies to an estimate of the charge provided under this subsection for a patient who is not insured:

a. If the health care provider determines, on the basis of preliminary information, that the patient is eligible for Medical Assistance or is eligible for but not enrolled in Medicare and the health care provider accepts recipients of Medical Assistance or beneficiaries of Medicare, the estimate of the charge shall include the paid rate ~~received by the health care provider for a patient who is a recipient of Medical Assistance or a beneficiary of Medicare, whichever is applicable,~~ or a rate lower than that rate; shall contain language that encourages the patient to review the estimate carefully and to apply for Medical Assistance or enroll in Medicare, as applicable; and shall inform the patient or the patient's agent of the requirements of s. 49.49 (3m) (a) 2.

b. If the health care provider cannot determine if the patient is eligible for Medical Assistance or Medicare, the estimate of the charge shall include the average paid rate paid by insurers and self-insured health plans or a rate lower than that rate; shall contain language that encourages the patient to review the estimate

carefully and to obtain insurance coverage; and shall inform the patient or the patient's agent of the terms and conditions under which the average paid rate or another paid rate may be applicable.

(4) (a) In this subsection, "consumer price index" means the average of the consumer price index over each 12-month period, all items, U. S. city average, as determined by the bureau of labor statistics of the U. S. department of labor.

(b) The department shall, by rule, biennially adjust the dollar amount that is specified for minimum cost under sub. (1) (n) by calculating any percentage difference between the consumer price index for the 12-month period ending on December 31 of the most recent odd-numbered year and the consumer price index for the 12-month period ending on December 31 of the next most recent odd-numbered year and applying that percentage difference, if any, to the most-recently specified dollar amount for minimum cost under this subsection or sub. (1) (n). If a percentage difference exists, the department shall by rule prescribe a revised dollar amount, rounded to the nearest $50 increment, that reflects the percentage difference, which amount shall be in effect until a subsequent rule is promulgated under this subsection. Notwithstanding s. 227.24 (1) (a), (2) (b), or (3), the department is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 6. 185.981 (4t) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,

632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.71 of the statutes is created to read:

609.71 Disclosure of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.798.

SECTION 9. 632.798 of the statutes is created to read:

632.798 Disclosure of information. (1) DEFINITIONS. In this section:

(a) "Cost-sharing requirements" means copayments, deductibles, coinsurance percentages, and any other cost-sharing mechanisms that apply under a health care plan or self-insured health plan.

(b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(c) "Insured" means a person covered under a health care plan offered by an insurer or an enrollee under a self-insured health plan.

(d) "Insured's agent" means a parent, guardian, or legal custodian of an insured who is a minor child; the spouse of an insured; an agent of an insured under a valid

power of attorney for health care; a guardian of the person, as defined in s. 54.01 (12), of an insured; or anyone authorized by an insured to act as his or her agent.

(e) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that provides coverage, excluding public coverage, of health care expenses under health care plans covering individuals or groups in this state. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01 (3).

(f) "Participating" has the meaning given in s. 609.01 (3m).

(g) "Provider" means a health care provider, as defined in s. 146.81 (1).

(h) "Public coverage" means coverage for health care expenses that is funded in whole or in part under any state-assisted or federally assisted program, including Medical Assistance under subch. IV of ch. 49 and Medicare under 42 USC 1395 to 1395hhh, the average paid rate of which is lower than an insurer's average paid rate for the same medical service.

(i) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) INFORMATION REQUIRED. An insurer or self-insured health plan shall provide any of the following information if requested by an insured or an insured's agent:

(a) A description of the coverage, including benefits and cost-sharing requirements, under the insured's health care plan or self-insured health plan.

(b) A description of pre-certification or other requirements, if any, that an insured must complete before any care is approved by the insurer or self-insured health plan.

(c) A summary of the insured's coverage with respect to a specific medical service or course of treatment, including all of the following information:

1. The estimated total and type of out-of-pocket costs that the insured may incur, including deductibles, copayments, coinsurance, and items and other charges that are not covered by the insurer or self-insured health plan.

2. An estimate of the amount or rate that the insurer or self-insured health plan will pay to a provider for the specific medical procedure or course of treatment. The estimate under this subdivision may provide the payment amount or rate in such a way that protects the insurer's proprietary pricing, but shall be a reasonably close estimate of the actual amount or rate that will be paid.

3. Any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from a provider that is not a participating provider. If the insured provides to the insurer or self-insured health plan the applicable medical code or codes for the service or course of treatment provided or proposed to be provided by a provider or providers that are not participating, the insurer or self-insured health plan shall inform the insured if the cost of the service or course of treatment exceeds the allowable charge under the insurer's or self-insured health plan's guidelines for payment for the service or course of treatment under the insured's health care plan or self-insured health plan.

4. Any discounts or financial incentives that the insurer or self-insured health plan is willing to offer the insured, including incentives for the insured to obtain care or a course of treatment from a different provider.

5. That the information in the summary represents the insurer's or self-insured health plan's best estimate of the amounts provided.

(3) GENERAL PROVISIONS. (a) The information under sub. (2) may be provided to the insured electronically or verbally, whichever is preferred by the insured.

(b) The insurer or self-insured health plan shall make a good faith effort to provide accurate information to the insured under sub. (2).

(c) An insurer or self-insured health plan may satisfy the requirement to provide any of the information under sub. (2) by providing a method by which an insured or insured's agent may obtain the information on his or her own, such as on a Web site.

SECTION 10. Initial applicability.

(1) DISCLOSURE OF INFORMATION. If a health care plan or a governmental self-insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a health care provider and a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with this act, this act first applies to that health care plan, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

(1) This act takes effect on the first day of the 19th month beginning after publication.

(END)

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either (1) for a patient who is insured or uninsured, provide an estimate of the charge to the patient or the patient's agent; or (2) for a patient who is insured, provide the patient's insurer or self-insured health plan with an estimate of the charge as the basis for information the insurer or self-insured health plan must provide on request of the insured.

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1. For a patient who is insured or who is not insured, provide the patient or the patient's agent with an estimate of the charge.

2. For a patient who is insured, provide the patient's insurer or self-insured health plan with an estimate of the charge as the basis for complying with the insured's request under s. 632.798.

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f. The estimate of the charge shall include the identity of the health care provider or the individual identities of the group of health care providers, if applicable, and the address of the applicable facility with which each health care provider is associated.

end A inserts

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3900/2dn
DAK&PJK:bk:pg

Date

To Representative Vukmir:

Please note the following changes to the material you proposed in your e-mail of February 4:

1. For #1. of that e-mail, I think you wanted removal of p. 7, lines 17 to 20, not 27; correct?

2. For #5. of that e-mail, instead of placing this material on p. 10 of the draft as s. 146.903 (3) (c) 3.c., I drafted it as s. 146.903 (3) (a) 2. Essentially, it appears to replace the language formerly under s. 146.903 (3) (a) 1., which you, in #1. of your e-mail requested be removed. Please review.

3. I deleted s. 146.903 (3) (c) 1. d. ("The estimate of the charge shall be made available to the patient or the patient's agent.") This is now redundant to s. 146.903 (3) (a) (b).

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